Medicare Learning Network
MLN Matters
CMS
Information for Medicare Fee-for-Service Health Care Professionals

NEWS FLASH	If you treat a Medicare Advantage enrolled beneficiary and you have questions about their Medicare Advantage Plan, you may wish to contact that plan. A plan directory and MA claims processing contact directory are available at *http://www.cms.hhs.gov/MCRAdvPartDEnrolData/* on the CMS website. CMS updates this site on a monthly basis.

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Note: This article was revised on December 12, 2007, to provide additional clarification. Some language regarding emergency and non-emergency transports and the Physician Certification Statement was removed and readers are referred instead to the actual regulations. In addition, some language was added as reflected in print that is bold, italicized and underscored.

Medicare Payments for Ambulance Transports

Provider Types Affected

Providers, physicians, and suppliers who bill Medicare fiscal intermediaries (FIs), carriers, and A/B Medicare Administrative Contractors (MAC) for ambulance services or who initiate ambulance transports for their Medicare patients.

Provider Action Needed

STOP – Impact to You

According to a recent study conducted by the Office of the Inspector General (OIG), "Medicare Payments for Ambulance Transports," during the calendar year 2002, twenty-five percent of ambulance transports did not meet Medicare's program requirements. This resulted in an estimated $402 million of improper payments. In two out of three cases, third-party providers (most likely not the

patient) who requested transports may not have been aware of Medicare's requirements for ambulance transports.

CAUTION – What You Need to Know

Liability for overpayment resulting from a denied ambulance transport claim depends on the type of denial. A denial due to coverage reasons (such as when other forms of transportation are not contraindicated) may result in a liability to the Medicare beneficiary. Claims denied due to level of service requirements are often down-coded to a lower level of ambulance service. In this case, the ambulance supplier is generally liable in the event of an overpayment. ***Please keep in mind that any discussion in this article does not supersede CMS' rules, regulations, manual instructions, or the Social Security Laws.***

GO – What You Need to Do

Please refer to the *Background* and *Additional Information* sections of this article and make certain that, if there are other payers, these situations are identified. It is important to know whether the use of an ambulance transport for your patient would be covered by Medicare, and if so, what level of service would be covered. Please refer to the *Background* section of this Special Edition article for information about payment and level of service requirements for ambulance transports.

Background

Some key provisions of the OIG Report are as follows:

Medicare Coverage of Ambulance Transports

When evaluating coverage of ambulance transport services, two separate questions are considered:

1. Would the patient's health at the time of the service be jeopardized if an ambulance service was not used? If so, Medicare will cover the ambulance service whether it is emergency or non-emergency use of the transport. If not, the Centers for Medicare & Medicaid Services (CMS) will deny the transport claim. Additionally, Medicare does not cover non-ambulance transports.
2. Once coverage requirements are met, Medicare asks the following question: What level of service (determined by medical necessity) is

appropriate with regard to the diagnosis and treatment of the patient's illness or injury? If the incorrect level of service is billed and subsequently denied, Medicare will usually reimburse at a lower rate reflecting the lower level of services judged appropriate.

Levels of ambulance service are differentiated by the equipment and supplies carried in the transport and by the qualifications and training of the crew. They include:

a) Basic *Life Support (BLS)*

b) Advanced *Life Support (ALS) – Level 1 (ALS1) and Level 2 (ALS2)*

c) Specialty *Care Transport (SCT)*

d) Air transport – fixed wing and rotary wing

In addition, both the BLS and ALS1 levels of ambulance service can be categorized as either emergency or non-emergency. As defined in 42 CFR 414.605, an emergency response means responding immediately at the BLS or ALS1 level of service to a 911 call or the equivalent in areas without a 911 call system. An immediate response is one in which the ambulance entity begins as quickly as possible to take the steps necessary to respond to the call.

Documentation Requirements

Ambulance suppliers are not required to submit documentation in addition to the uniform Medicare billing form CMS-1500 submitted by independent ambulance suppliers to Medicare carriers or A/B MACs or the UB-04 (form CMS-1450) billed to FIs or A/B MACs by ambulance suppliers that are owned by or affiliated with a Medicare Part A provider such as a hospital.

However, ambulance suppliers are required to retain documentation that contains information about the personnel involved in the transport and the patient's condition and to *make that documentation available to* Medicare FIs, carriers, and A/B MACs upon request. Ambulance suppliers are also required to obtain a Physician Certification Statement (PCS) for non-emergency transports in some circumstances. *These circumstances are defined in 42 CFR 410.40(d)(2) and 42 CFR 410.40(d)(3)* (see 42 CFR 410.40 link in the Additional Information section).

How to Avoid Improper Billing

- Be sure that coverage criteria and level of service criteria for ambulance transport are met and that it is backed up with the appropriate documentation. For guidance, you may wish to refer to change request (CR) 5442 "Ambulance Fee Schedule – Medical Conditions List – Manualization," which contains an

educational guideline that was developed to assist ambulance providers and suppliers ***in*** communicat***ing*** the patient's condition to Medicare FIs, carriers, and A/B MACs as reported by the dispatch center and as observed by the ambulance crew. The link to this CR is provided below.

- Maintain documentation that will help to determine whether ambulance transports meet program requirements when Medicare FIs, carriers, and A/B MACs conduct medical reviews. Be sure to send complete documentation when requested by your FI, carrier, or A/B MAC. Generally, coverage errors for emergency transports were due to documentation discrepancies between the ambulance supplier and the third-party provider (e.g., emergency room records).
- Note whether your FI, carrier, or A/B MAC has implemented origin or destination modifiers such as for a dialysis facility and for non-emergency transports to and from a hospital, nursing home, or physician's office. Be sure to include these modifiers (if available) when billing for ambulance services. They will help your FI, carrier, or A/B MAC to determine, through a prepayment edit process, whether the coverage and/or level of service for ambulance use is correct.

Additional Information

SE0724 is based on the January 2006 U.S. Department of Health and Human Services (HHS) OIG report, *Medicare Payments for Ambulance Transports*, which is located at *http://oig.hhs.gov/oei/reports/oei-05-02-00590.pdf* on the OIG HHS website.

CR 5442, dated February 23, 2007, "Ambulance Fee Schedule – Medical Conditions List – Manualization Revisions," is located at *http://www.cms.hhs.gov/transmittals/downloads/R1185CP.pdf* on the CMS website.

The regulations at 42 CFR 410.40(d)(2) and (3) state the circumstances when a PCS is required and may be found at *http://www.cms.hhs.gov/AmbulanceFeeSchedule/downloads/cfr410_40.pdf* on the CMS website.

If you have questions, please contact your local Medicare contractor at their toll-free number, which may be found in the Provider Call Center Toll-Free Numbers Directory. The directory is available in the "Downloads" Section of the Medicare Learning Network Contact Us Page located at *http://www.cms.hhs.gov/MLNGenInfo/30_contactus.asp* on the CMS website.